STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING _____ B. WING _____	C 08/17/2017

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MANORCARE HEALTH SERVICES - WILMINGTON	700 FOULK ROAD WILMINGTON, DE 19803

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from August 10, 2017 through August 17, 2017. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 117. The Stage 2 survey sample size was 33. Abbreviations / definitions used in this 2567 are as follows: < - decreased, less than; x's - times; @ - at; & - and; ADL - Activities of Daily Living; ADON - Assistant Director of Nursing; BM - bowel movement; CM - centimeter; CNA - Certified Nurse's Aide; DON - Director of Nursing; EHR - Electronic Health Record; LTC - Long Term Care; LPN - Licensed Practical Nurse; L-left; MDS Minimum Data Set; NHA - Nursing Home Administrator; NSS - normal saline solution; OT - Occupational Therapy/Therapist; POA - power of attorney; PT - Physical Therapy/Therapist; PU - Pressure Ulcer; R-right; RN - Registered Nurse; RNAC - Registered Nurse Assessment	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/15/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		

Coordinator;
TAR-treatment administration record;
eTAR - electronic treatment administration record;
Absorbent - material that soaks up liquid;
Always incontinent - no episodes of controlled or continent voiding/urinating;
Amputation- the intentional surgical removal of a limb or body part;
Bladder Diary - a record of urinating for seventy two (72) hours and/or 3 days;
cm-Centimeter - a measurement, 1 centimeter = 0.39 inches or metric measurement of length;
Cognitively intact - able to make needs known;
Commode - portable toilet or apparatus placed over toilet;
Continent - control of bladder and bowel function;
Dementia - persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning;
Dentition- teeth;
Depression-sad mood;
Eczema-itchy, dry,red skin caused by inflammation;
Edentulous - lacking teeth or toothless;
Extensive assistance - resident involved in activity, staff provide weight-bearing support;
Expulsion - forcing something out of the body;
Foley catheter - a tubular, flexible instrument inserted and retained in the bladder by a balloon to empty urine from the bladder;
Frequently Incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day look back period;
Functional Incontinence - when a resident is usually aware of the need to urinate but for a physical or mental reason he/she is unable to get to a bathroom;

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F 000	Continued From page 2 Grievance - complaint or concern regarding care and service; Hospice - care for the terminally ill; Hoyer lift - a mechanical device that allows a person to be lifted and transferred with a minimum of physical effort; Hydrocolloid dressing - a dressing with a substance that forms a gel with water/fluid; Incomplete quadriplegia - spinal cord injury where incomplete mean some sensation or movement below the level of injury; Incontinent/incontinence - loss of control of bladder &/or bowel function; Kardex - CNA plan of care for individual residents; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; Naturopathic - a system of treatment of disease that avoids drugs and surgery and emphasizes the use of natural agents (such as air, water, and herbs) and physical means (such as tissue manipulation and electrotherapy; Neurogenic bladder - a person lacks bladder control due to a brain, spinal cord, or nerve condition; Neurology - study and treatment of disorders that affect the brain, spinal cord, and nerves; Patent - open; Periwound - the area immediately around the wound; Pinochle - card game; Pressure Ulcers (PUs) - sore area of skin that develops when the blood supply to it is cut off due to pressure; RAI-Resident Assessment Instrument; Risamine ointment-used to treat and heal skin irritation caused by urine, diarrhea and sweat; Sacrum - large triangular bone at base of spine; Scoop mattress - a scoop shaped foam that fits	F 000		

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F 000	Continued From page 3 over a hospital bed sized mattress; the scoop design assists people by giving them a barrier from rolling out of bed; Spasms - involuntary muscle contraction, or a group of muscles causing sudden pain; Stage II (2) - skin blisters or skin forms an open sore. The area around the sore may be red and irritated; Stand up lift - lifts specifically designed to secure patients during transfers from a seated position to a standing position, enabling quicker, easier, and safer patient lifting and transfer for both the patient and the caregiver; Topically - relating or applied directly to a part of the body; Toileting plan-set times for a resident to go to the toilet; Urge incontinence - loss of urine with an abrupt and strong desire to urinate; usually loss of urine en route to toilet; Urinary catheter - a tubular, flexible instrument inserted and retained in the bladder by a balloon to empty urine from the bladder; Urinary continence - ability to prevent accidental leakage of urine from the bladder; Urinary incontinence -UI- inability to prevent accidental leakage of urine from the bladder; UTI- urinary tract infection; Vitamin A and D ointment-medication used to treat dry, rough, scaly skin; Voiding diary - a record of voiding (urinating) for 72 hours and/or 3 days to determine if a pattern exists.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes.	F 157		10/1/17

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F 157	Continued From page 4 (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 157		

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F 157	Continued From page 5 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R43) out of 33 Stage 2 sampled residents, the facility failed to immediately notify the resident's physician when there was a significant change in the resident's physical status which may have required physician intervention. Findings include: Cross refer to F315, example 2 R43 had a diagnosis of a neurogenic bladder and usage of a foley catheter. 11/30/16 - A physician's order stated to maintain a foley catheter for R43 on every shift. 7/2/17 at 7:12 AM - A progress note stated that R43 does not have a foley. Review of R43's clinical record lacked evidence of physician notification to determine if further interventions were needed when the foley catheter came out. 8/17/17 at 9:26 AM - During an interview, E3 (ADON) and E4 (Staff Development RN) confirmed the findings after reviewing R43's clinical record. The facility failed to immediately notify the physician to determine if further interventions were needed when R43's foley catheter came out.	F 157	A. The facility failed to notify the physician when a patient's indwelling catheter was dislodged. R43, was impacted by this deficient practice. The resident's physician has been notified of dislodged/ discontinued indwelling catheter and an order was obtained to discontinue the order stating to maintain indwelling catheter and no additional physician recommendations were received post discontinuation of indwelling catheter. In order to protect residents in similar situations, the facility will immediately notify the resident's physician when there is a significant change in the resident's physical status which may require physician intervention. B. Residents residing in the facility with indwelling catheters have the ability to be affected by this deficient practice. Director of Nursing/ designee performed an initial audit to identify residents with indwelling catheters and that they have orders and the indwelling catheters are in place. C. DIRECTOR OF NURSING/Designee will in-service licensed nursing staff that when a residents indwelling catheter becomes dislodged/discontinued the	

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F 157	Continued From page 6 Findings were reviewed during the Exit Conference with E1 (NHA), E3 and E4 on 8/17/17 at 7 PM.	F 157	physician is notified for further orders to include obtaining an order of discontinuation of maintain indwelling catheter DIRECTOR OF NURSING/Designee will in-service licensed that residents whose indwelling catheter orders have been discontinued are to be placed on 24 hour report D. DIRECTOR OF NURSING/ designee will audit residents identified with indwelling catheter orders to validate that the indwelling catheter is in place. This audit will be conducted weekly x 4 then monthly x 2 to ensure substantial compliance. DIRECTOR OF NURSING /designee will audit 24 hour reports to validate that residents that have had their indwelling catheters discontinued are placed on 24 hour report. This audit will be conducted weekly x 4, then monthly x 2 to ensure substantial compliance. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	
F 247 SS=D	483.10(e)(6) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(6) The right to receive written notice, including	F 247		10/1/17

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F 247	Continued From page 7 the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide notification of roommate change before the change was made for 1 (R71) out of 33 Stage 2 sampled residents. Findings include: In an interview on 8/10/17 at 2:00 PM, R71 stated she did not know who her new roommate was and when she was moving in, until the day her new roommate moved in, adding she was not informed. On 8/16/17 at 2:15 PM, R71 again stated she did not receive notification, verbal or written, about a new roommate moving in to her room. In an interview on 8/16/17 at 9:55 AM, E10 (Admissions Director) described the process of notifying the resident and/or responsible party, of room/roommate changes and documenting the notification in the Notification of Room/Roommate Change form in the electronic medical record system. Review of R71's medical record revealed the absence of a completed Notification of Room/Roommate Change regarding a roommate change. R71's medical record also indicated she is her own responsible party. These findings were reviewed with E1 (NHA) and E3 (ADON) on 8/17/17 at 7:00 PM.	F 247	A. The facility failed to notify a resident when they would be receiving a new roommate. R 71 was impacted by this deficient practice. The roommate of R71 has been moved to another room per roommates request and the A bed is currently empty. In order to protect residents in similar situations, the facility will notify residents via written notice to include the reason for the change before the resident's room/ roommate in the facility is changed B. Residents residing in the facility that will have a room/ roommate change have the ability to be affected by this deficient practice. DIRECTOR OF NURSING/ designee performed initial audit of current patients residing in semi- private rooms in the facility who have received new roommates on or after 8/17/17, for written and documented notification via Room/ Roommate change CARE AREA ASSESSMENT and progress note. C. STAFF DEVELOPMENT COORDINATOR/ designee will educate Admissions, Social Services, and licensed nursing, of need to notify patient in writing of room/ roommate changes prior to their arrival. STAFF DEVELOPMENT COORDINATOR/ designee will educate Social Services and Licensed nurses to complete room/ roommate change CARE	

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F 247	Continued From page 8	F 247	AREA ASSESSMENT and to document a progress note reflecting notification. D. Auditing will be conducted on 10 random charts of residents who received a new roommate daily x 2weeks, weekly x 2, and monthly x2 to ensure substantial compliance. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	
F 248 SS=E	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, it was determined the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities	F 248	A. Residents 43, 71,123,168,186,207, and 242 have been re-evaluated & reviewed; care plans updated to better meet their past & current leisure interests and social needs to create an individualized activity plan of care. In order to protect residents in similar situations,	10/1/17

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F 248	Continued From page 9 and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for seven (R43, R71, R123, R168, R186, R207, and R242) out of 33 Stage 2 sampled residents. 1. Review of R207's facility clinical record revealed the following: A hospital record, present in R207's facility clinical record, revealed a "Supportive and Palliative Care Consult Note," dated 7/13/17, which stated that during an interview with R207's son it was revealed the resident had enjoyed playing pinocle and was on the Altar Society at her church. R207 was admitted to the facility on 7/20/17, following hospitalization, with diagnoses that included dementia with behavioral disturbance and recurrent depression. R207 resided on the facility's Arcadia unit (locked dementia unit). 7/21/17 - A Social Service Assessment & History stated R207's profession/vocation was homemaker, that her religious preference was Catholic and that the last grade she had completed was grade 8. 7/27/17 - The admission MDS assessment stated R207's daily decision making skills were severely impaired (never/rarely made decisions), and that she required extensive assistance of one staff person for walking in her room and/or corridor and for locomotion on and/or off the unit. The MDS assessment stated that Section F, listing R207's activity preferences, was completed	F 248	Recreation Director/ Designee will provide ongoing programs of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. B. Residents residing in the facility have the ability to be impacted by this deficient practice. Residents are evaluated/ assessed upon admission and annually and reviewed quarterly regarding individual leisure needs and interests. Creating a resident centered care plan, focusing on each resident's individualized interests, preferences and current capabilities; identifying residents who are dependent on staff for activities, are identified on activity evaluation & reviewed annually. Recreation staff will focus on providing activity programming, to ensure compliance based upon residents individual interest & preferences. C. Recreation Director/ Designee will in-service recreation staff regarding the expectations of program attendance for residents based on their preferences and interests. Recreation Department will offer evening programs 2x per week, and continue weekend programing for residents. Detailed below are the measures and system changes the facility will follow to ensure the problem does not occur. It is the practice of this facility to provide programs of activities designed to meet, in accordance with the comprehensive	

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F 248	Continued From page 10 based on staff interview. There was no evidence that R207's family was interviewed regarding the resident's activity preferences. The MDS listed the following as preferences: reading books, newspapers, or magazines; listening to music; being around animals such as pets; doing things with groups of people; participating in favorite activities; spending time outdoors; and participating in religious activities or practices. 7/27/17 - A Recreation/Activity Evaluation stated that R207's lifetime occupation and educational level were "unknown." The evaluation listed the following as R207's current interests: pets will visit; arts & crafts with assistance; cards/games with assistance; children/intergenerational visiting groups; cooking/baking sensory; current events/news; music; outdoor activities enjoys nice weather; entertainment; puzzles/word games with assistance; talking books; religious involvement; talking/conversing with staff and peers; current events group; exercise/physical activities with assistance; gardening/plants with assistance; movies special activity; TV. Additionally, the evaluation stated "If other interests, religious or cultural preferences, please list along with the specific type: This assessment was completed on staff observation of (name of R207). She will be invited in (sic) a variety of group activities in order to increase her quality of life." The evaluation also identified that R207 required assistance with her wheelchair. 7/27/17 - The facility developed R207's activity care plan with the focus "Enjoys activities such as arts and crafts, reading-talking books/magazines, listening to a variety of music and social interactions with peers and staff." The goal of the care plan was "...will socialize with peers 1-2 x	F 248	assessment, the interests and the physical, mental and psychosocial well-being of each resident. The recreation director/designee will perform audits to ensure activity programming of residents' interest and preferences are offered. Recreation director/ designee will perform audits to ensure evening activities are provided 2x per week, and Weekend activities continue to be offered. D. The recreation Director/ designee will conduct audit of current residents' program attendance to ensure residents are provided the opportunity to be involved in activities of interest and preference. Ongoing audit will occur 5x per week for one week, weekly for 3 weeks, and if appropriate monthly for 2 months to ensure substantial compliance. Recreation Director or designee will conduct audit of recreation calendar to ensure evening programs are offered 2x per week, and that programming continues to be offered on the weekends. Audit will occur once per month and monthly for 2 months to ensure substantial compliance. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	

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F 248	Continued From page 11 per week during activities consistent with likes and interests such as arts and crafts, talking books and musical/social events." Interventions included: assist in planning and/or encourage to plan own leisure time activities; assist to transport to & from activities of choice; encourage participation in group activities of interest; offer redirection and diversion as needed; offer/supple large print materials; provide supplies/materials for leisure activities as needed/requested. Review of R207's Daily Recreation/Activity Participation Documentation from 7/21/17 through 8/15/17 revealed the following: - Arts and crafts - Documented resident was a passive participant on 7/24/17, 7/26/17, 7/30/17 and was an active participant on 8/1/17 and refused on 8/10/17; - Cooking - Documented resident was active on 8/7/17 and passive on 8/14/17; - Music/Singing - Documented resident was active daily from 7/21/17 through 8/15/17; - Sensory Stimulation - Documented resident was active from 7/28/17 through 7/31/17, 8/1/17, 8/3/17, 8/7/17, 8/14/17 and 8/15/17; - Social Programs - Documented resident was active on 7/22/17; - Socializing - Documented resident was active daily from 7/21/17 through 8/15/17; - Special and Theme Events - Documented resident refused on 8/11/17 - Spiritual/Religious Activities - Documented resident was active 7/23/17 and 7/24/17; - Talking Books - Documented resident was passive on 8/3/17, 8/7/17, 8/10/17, and 8/14/17. There was no evidence there were any pet visits in the facility and no evidence that R207 was ever taken outdoors to enjoy nice weather according to her preferences.	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 248	Continued From page 12 Review of the Arcadia July and August 2017 activity calendars revealed the following: - 7/28/17, 8/4/17, 8/11/17 - The calendar listed gardening as an activity those days. R207's Recreation/Activity Evaluation, dated 7/27/17, listed gardening as a current interest, yet there was no evidence that the facility invited/escorted the resident to these gardening activities and/or that she refused. - 7/26/17, 8/2/17, 8/9/17 - The calendar listed Bible Stories as an activity those days. R207's Recreation/Activity Evaluation, dated 7/27/17, listed religious activities as a current interest, yet there was no evidence that the facility invited/escorted the resident to these religious activities and/or that she refused. The following observations were made of R207: 8/14/17 at 11:15 AM - R207 was seated at a back table in the lounge/large dining room on the Arcadia unit. R207 was not engaged in any activity. E23 (Activity Assistant) was at the front of the room mixing ingredients for a peach cake. E23 was mixing the ingredients at one table with three (3) residents watching. Other residents, including R207, who were seated at other tables were not involved. After the peach cake was placed to bake, E23 sat at the same table of residents that had watched her prepare the peach cake and began to clean off large different colored lego type blocks. 8/14/17 at 11:30 AM - A yarn-like item was placed on the table in front of R207. The staff did not interact with R207. R207 was observed pushing the item away from herself to the center of the table.	F 248		

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F 248	Continued From page 13 8/14/17 at 11:37 AM - E23 began reading short stories from "Chicken Soup for Women's Soul." R207 was observed trying to reach an activity item that was in front of another resident at her table, who was not engaged in the item, but the other resident yelled "No!" There was no staff intervention. 8/14/17 at 3:04 PM - R207 was observed lying on her bed with eyes closed. 8/15/17 at 9:42 AM - R207 was observed seated in a chair at the table in the Arcadia lounge/large dining room. Oldies music was playing and E19 (Activity Assistant) was placing activity items on the tables in front of each resident. Again there was no interaction with R207 at this time. 8/15/17 at 10:44 AM - R207 was observed seated in a chair in the hallway outside a room near the Arcadia large dining room DR entrance. 8/15/17 at 10:56 AM - R207 remained seated on the chair in the hallway. 8/15/17 at 11:20 AM - R207 remains seated on the chair in the hallway, with her walker next to her within reach, when she stood to walk away leaving the Rolling Walker behind. Staff redirected her to get the walker. 8/15/17 at 11:35 AM - R207 was seated in a chair at a table in the Arcadia large dining room with large lego type blocks in front of her. There was no staff interacting with R207 and the resident was not engaged in doing anything with the blocks.	F 248		

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F 248	Continued From page 14 8/15/17 at 1:52 PM - R207 was observed ambulating down the hall with her walker. 8/15/17 at 4:28 PM - R207 observed asleep on her bed. 8/16/17 at 8:22 AM - R207 was observed seated in a chair in the hallway across from her bedroom. 8/16/17 at 9:39 AM - R207 seated in a chair in the Arcadia large dining room and oldies music is playing. R207 was not engaged in any activity. 8/16/17 at 2:10 PM - A Catholic religious activity was observed in the New Castle unit lounge. R207 was not present. At 2:17 PM - R207 was observed standing in the hallway in the Arcadia unit where she attempted to open another resident's bedroom door. Staff removed R207 from the door at which time she became tearful and sat in a chair in the hallway. The facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for R207. 8/16/17 at approximately 2:30 PM - During an interview with E25 (Activity Director) findings were reviewed. When asked if R207 was invited and or escorted to the Catholic Mass on 8/16/17, E25 stated that she was unsure whether the resident	F 248		

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F 248	Continued From page 15 was Catholic. 8/17/17 at approximately 7:00 PM - Findings were reviewed with E1 (NHA), E3 (ADON), E4 (Staff Development RN), and E6 (Corporate Quality Assurance Consultant). 2. R123 was admitted to the facility on 12/29/16 with diagnoses that included dementia and depression. R123 resided on the facility's Arcadia unit (locked dementia unit) and was receiving Hospice services. Review of R123's clinical record revealed the following: 1/11/17 - The Recreation/Activity Evaluation stated R123's lifetime occupation and education level were "unknown." The evaluation listed the following as current interests: animals/pets; music; arts and crafts; outdoor activities; parties/socials; bingo/cards games; watching cooking/baking; religious involvement (Protestant); talking/conversing; TV/radio; 1/11/17 - A care plan, last revised on 7/5/17, was developed for "Enjoys activities such as animal and pet visits, news/TV/movies, outdoor opportunities, arts and crafts, religious services, card games, bingo, cooking and listening to music/entertainment. Care plan interventions included: assist in planning and/or encourage to plan own leisure time activities; assist to transport to & from activities of choice; encourage participation in group activities of interest; offer redirection and diversion as needed; provide 1:1 activity visits of potential interest 1-2 x per week; provide supplies/materials for leisure activities as needed/requested.	F 248		

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F 248	Continued From page 16 6/21/17 - A significant change MDS assessment stated R123's daily decision making skills were severely impaired (never/rarely makes decisions). The MDS assessment stated that Section F, listing R207's activity preferences, was completed based on staff interview. The MDS listed the following as preferences: listening to music; being around animals such as pets; doing things with groups of people; spending time outdoors; participating in religious activities or practices. Review of the Daily Recreation/Activity Participation Documentation for July and August revealed there were no pet visits, or outdoor activities as per R123's identified interests. 7/16/17 - The Arcadia activity calendar revealed a religious service was planned, yet there was no evidence that R123 was escorted to the service according to her identified preferences. The following observations were made of R123: 8/14/17 11:00 AM - R123 was seated in a chair across from her bedroom in the hallway. A staff person took R123 into her room to change her shirt when she spilled a beverage. 8/14/17 11:16 AM - R123 was wheeled into the Arcadia large dining room in a wheelchair while a Hospice music therapist was playing a guitar and singing for another resident. R123 smiled upon entering the room and clapped her hands. 8/14/17 11:27 AM - E23 (Activity Assistant) placed a magazine in front of R123 where she was seated at a table in the Arcadia dining room. R123 did not look at the magazine and there was	F 248		

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F 248	Continued From page 17 no staff interaction with the resident. 8/14/17 11:43 AM - R123 began to turn the magazine pages. E23 reads short stories aloud to the room. 8/14/17 11:49 AM - The Hospice music therapist visits with R123, who does interact with the therapist. 12:02 PM - The Hospice music therapist is playing the guitar and singing to R123. R123 continues to flip through the magazine pages. 8/14/17 3:06 PM - R123 was seated in a wheelchair at a table in the Arcadia dining room with her eyes closed. Oldies music was playing while E23 (Activity Assistant) was seated at a table with two other residents and was cutting out colored pictures. 8/15/17 8:16 AM - R123 was observed being wheeled into the Acadia large dining room in a wheelchair for breakfast. 8/15/17 9:35 AM - R123 observed seated at a table in the large Arcadia dining room with three other residents. Oldies music was playing. R123 was rubbing her hands and face repeatedly. There was no staff interaction observed. 8/15/17 10:44 AM - R123 was observed seated at a table in Arcadia dining room with a beverage in front of her. R123 had large plastic dice in front of her which she was not engaged in. Oldies music was playing and E19 (Activity Assistant) was in the room moving around every few minutes from table to table reading to residents in a very soft voice. E16 (CNA) was in the room passing out beverages and snacks. E17 (CNA orientee) was	F 248		

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F 248	Continued From page 18 seated at a table with three residents, one of which she is showing how to do an activity item with locks. 8/15/17 11:35 AM - R123 was seated at a table in the Arcadia dining room, not engaged in any activity. 8/15/17 1:54 PM - R123 was seated at a table in the Arcadia dining room working on the activity board with locks. There were 19 residents observed in the room, only two of which were engaged or attempting to do an activity board. E19 was seated at a table with three residents and was matching puzzle pieces together. E19 was not interacting with the residents, nor were any of them engaged in the puzzle pieces she was working on. 8/15/17 3:05 PM - R123 remains seated at the table where she was earlier, not engaged in any activity. E19 remains in the room at the corner table near the entrance door, not engaged with any resident. Two CNAs [E17, E17] were observed in the room, one CNA has a laptop in front of her and is talking to the other CNA. 8/15/17 4:31 PM - R123 was seated at a table with 2 other residents and not engaged in any activity. 8/16/17 9:38 AM - R123 was seated at a table in the Arcadia dining room with her head down. Oldies music was playing. There was no activity staff present in the room, but a CNA was placing activity items in front of each resident. R123 had an activity item in front of her, but was not engaged.	F 248		

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F 248	Continued From page 19 8/16/17 1:55 PM - R123 was seated at a table with an activity item in front of her. R123 was not engaged in the item. Oldies music was playing. 8/16/17 2:25 PM - R123 was seated at a table in the Arcadia dining room, not engaged in any activity. Oldies music was playing and three CNAs (E20, E21 and E22) were in the room not interacting with any residents. The three CNAs were seated near each other and were conversing among themselves. Upon this surveyors entrance into the room, E21 and E22 got up and began interacting with residents. 8/16/17 4:30 PM - R123 was seated in the center of the Arcadia dining room watching another resident taking off his slipper socks. There was one CNA in the room interacting with one resident. The facility failed to provide for R123, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. 8/16/17 at approximately 2:30 PM - During an interview with E25 (Activity Director) findings were reviewed. 8/17/17 at approximately 7:00 PM - Findings were reviewed with E1 (NHA), E3 (ADON), E4 (Staff Development Nurse), and E6 (Corporate Quality Assurance Consultant).	F 248		

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F 248	Continued From page 20 3. During an interview on 8/10/17 at 11:07 AM, when asked "Are the activities provided as often as you would like, including weekends and evenings?" R186 responded "no activities after 5:30 PM." 4. During an interview on 8/11/17 at 9:30 AM, when asked "Are the activities provided as often as you would like, including weekends and evenings?" R43 responded "no, not in the evenings." 5. During an interview on 8/11/17 at 2:00 PM, when asked "Are the activities provided as often as you would like, including weekends and evenings?" R71 responded that activities are not offered as often as she would like on weekends and evenings. 6. During an interview on 8/10/17 at 9:45 AM, when asked "Are the activities provided as often as you would like, including weekends and evenings?" R168 responded that activities are not offered as often as she would like on weekends and evenings. 7. During an interview on 8/10/17 at approximately 1:00 PM, when asked "Are the activities provided as often as you would like, including weekends and evenings?" R242 responded "No," activities are not offered as often as she would like on weekends and evenings. 8/16/17 at approximately 2:30 PM - During an interview with E25 (Activity Director) findings were reviewed. E25 stated that they used to have evening activities in the past but only approximately six (6) residents would show up.	F 248		

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	085028	A. BUILDING _____ B. WING _____	C 08/17/2017

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F 248	Continued From page 21 The facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. 8/17/17 at approximately 7:00 PM - Findings were reviewed with E1 (NHA), E3 (ADON), E4 (Staff Development Nurse), and E6 (Corporate Quality Assurance Consultant).	F 248		
F 253 SS=B	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to provide maintenance and house keeping services services for 7 rooms (Dover 232, Heritage 204, 206, 210, Arcadia 113, and New Castle 141, and 143) out of 35 rooms surveyed. Observations made between 8/10/17 and 8/11/17 during the Stage 1 census record review and the Stage 2 environmental tour on 8/15/17 from 3:00 PM to 3:45 PM revealed the following: Dover 232 - There were marks on the wall near the TV;	F 253	A. Issues Identified in Rooms 232, 204, 206, 210, 113, 141, and 143 have been repaired/ corrected. In order to protect other residents in similar situation, the facility will continue with environmental rounds. B. Maintenance Director/ Designee will conduct environmental rounds to evaluate whether the facility is maintaining a sanitary, orderly and comfortable interior. Any findings will be addressed as residents residing in facility have the ability to be impacted.	10/1/17

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F 253	Continued From page 22 - The wallpaper was pealing off near the floor; - There were marks on the wall next to the window; Heritage 204 - The baseboard along the right side of the wall near the entrance was scraped; - The towel bar in the bathroom was loose; Heritage 206 - The chair rail is scraped; - The wall paper by the mirror was missing; - The long safety rail on the wall in the bathroom was slightly loose; Heritage 210 - The wallpaper along the left side of the wall is in disrepair as you enter room; Arcadia 113 - The caulking around the toilet was in disrepair; New Castle 141 - The towel bar was loose; New Castle 143 - The top of commode lid was improperly closed; - The towel bar was loose; - The wall paper in the bathroom was torn. All findings were reviewed and confirmed with E5 (Maintenance Director) on 8/15/17 at approximately 3:45 PM.	F 253	C. The issues identified during the annual survey had not been identified through rounds as requiring attention. Detailed below is the system changes and monitoring the facility will do in order to ensure the problem does not recur and solutions are sustained. It is the practice of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. The maintenance director/designee will perform random weekly audits using the environmental checklist to evaluate compliance to address any environmental findings. The staff development coordinator/ designee will in service Housekeeping staff on identifying and communicating environmental findings through the maintenance TELs, 24 hour report, or to Maintenance Director/ designee. D. The Maintenance Director/ Designee will perform random environmental audits on one room 5x per week for one week, then 6 rooms weekly for 3 week, and if appropriate monthly for 2 months using the environmental checklist to evaluate compliance and address any environmental findings to ensure substantial compliance. Results of these audits will be forwarded	

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F 253	Continued From page 23	F 253	to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion	F 272		10/1/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 272	Continued From page 24 of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to complete an accurate and complete comprehensive assessment for one (R213) out of 33 Stage 2 sampled residents in the area of urinary incontinence. Findings include: Cross refer to F315, example #1 The facility's Urinary Incontinence Management Practice Guide, dated 3/2012, was reviewed. The facility's instructions for a Bladder Diary stated, "...complete the 3 day bladder diary on all new admissions...". R213's clinical record revealed the following: The hospital History and Physical (H&P), dated 7/29/17, present in R213's facility clinical record, stated "...history of neurogenic bladder, and he does not have a Foley at present, as he is able to	F 272	A. The facility failed to complete a 3 day bladder diary, urinary incontinence CARE AREA ASSESSMENT, identify voiding pattern, and develop an individualized toileting plan. R213 was impacted by this deficient practice. R213 now has a 3 day bladder diary, urinary incontinence CARE AREA ASSESSMENT, identified voiding pattern, and an individualized toileting plan. In order to protect residents in similar situations the facility will follow the Incontinence Practice Guide by: completing a 3 day bladder diary upon admission, urinary incontinence CARE AREA ASSESSMENT, and develop an individualized toileting plan. B. Residents/ patients whom are newly admitted to the facility have the ability to be affected by this deficient practice. DIRECTOR OF NURSING/ designee conducted an initial audit of new	

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	085028	A. BUILDING _____ B. WING _____	C 08/17/2017

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F 272	Continued From page 25 sense when he needs to void...". 8/3/16 - A "Receiving Hospital Report" (nurse to nurse report from hospital to LTC facility) stated R213 was continent of bowel and bladder. 8/3/16 - R213 was admitted to the facility with diagnoses that included neurogenic bladder, incomplete quadriplegia and muscle spasms. 8/3/16 - The Patient Admission/Readmission Screen stated R213 had bladder and bowel incontinence. The facility failed to complete a 3 Day Bladder Diary, and Urinary Incontinence assessment at this time according to facility practice guidelines. The facility failed to identify voiding patterns and failed to develop an individualized toileting plan for R213. 8/10/16 - The admission MDS assessment stated R213 was cognitively intact, and required extensive assistance of 2 staff for bed mobility, transfers and toilet use. The MDS assessment also stated that R213 was frequently incontinent of bladder and always incontinent of bowel and there was no toileting program being used to manage either bowel or bladder incontinence. The facility failed to accurately and comprehensively assess R213 in the area of urinary incontinence. 8/17/17 approximately 7:00 PM - Findings were reviewed with E1 (NHA), E3 (ADON), E4 (Staff Dvelopment RN), and E6 (Corporate Quality Assurance Consultant) during the exit conference	F 272	admissions to the facility since 8/17/17 to identify other patients who have the ability to be affected by this deficient practice. The identified patients will have a 3 day bladder diary completed, urinary incontinence CARE AREA ASSESSMENT, and develop an individualized toileting plan. C. STAFF DEVELOPMENT COORDINATOR/ designee will in service licensed nursing staff that 3 day bladder diaries need to be initiated and completed on admission to the facility. STAFF DEVELOPMENT COORDINATOR/ designee will in service Unit Managers to evaluate 3 day bladder diaries, complete Urinary Incontinence CARE AREA ASSESSMENT, identify a voiding pattern, and develop an individualized toileting plan. D DIRECTOR OF NURSING/ designee will audit new admissions for the same process, daily x2 weeks, weekly x2 weeks, monthly x2 months to ensure substantial compliance. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	

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F 280	Continued From page 26	F 280		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs.	F 280		10/1/17

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F 280	Continued From page 27 (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 280		

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F 280	Continued From page 28 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, it was determined that for 2 (R43 and R123) out of 33 Stage 2 sampled residents, the facility failed to review and revise each resident's comprehensive care plans with respect to R43's urinary catheter and risk for urinary incontinence and R123's risk for falls. Findings include: 1. Cross refer to F315, example 2 Review of R43's clinical record revealed the following: 4/15/16 - R43 was care planned for an urinary catheter due to neurogenic bladder. 4/15/16 - R43 was care planned for being at risk for urinary incontinence despite the presence of a urinary catheter for neurogenic bladder related to bladder spasms and spontaneous catheter expulsion. The goal was for R43 was to be maintained as clean and dry as possible. Approaches included: ...provide incontinent care as needed...use absorbent products as needed. 7/2/17 through 8/16/17 - Review of R43's eTAR and progress notes revealed that she no longer had a urinary catheter. During this timeframe, R43's clinical record lacked evidence of a comprehensive assessment of her urinary status after she no longer had the urinary catheter, but continued to be incontinent of urine. 8/17/17 at 9:26 AM - During an interview, E3 (ADON) and E4 (Staff Development RN)	F 280	A. The facility failed to update an existing care plan for indwelling catheter when the catheter was discontinued and failed to initiate a new care plan as it relates to continence status after the indwelling catheter was removed. R43 was impacted by this deficient practice. R43's care plan has been revised to reflect her change in continence status. To protect other residents in similar situations the facility will update care plans when there is a change to indwelling catheters/ continence status and the intervention is no longer appropriate for the resident. Facility failed to update an existing care plan for risk for falls when a mattress intervention was resolved for safety. R123 was impacted by this deficient practice. It has been verified that the appropriate mattress is on R123's bed and that the care plan matches. To protect other residents in similar situations the facility will ensure that the mattress interventions on fall care plans are appropriate and in place. B. Residents residing in the facility whom have indwelling catheters in place are also at risk for the same deficient practice. DIRECTOR OF NURSING/ designee conducted an audit of patients currently residing in the facility who have indwelling catheters and or existing care plan for indwelling catheters, to validate that the care plan is appropriate.	

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F 280	Continued From page 29 confirmed that the facility failed to review and revise the two care plans (urinary catheter and being at risk for urinary incontinence) to reflect her current urinary care needs. Findings were reviewed during the Exit Conference with E1 (NHA), E3 and E4 on 8/17/17 at 7 PM. 2. Review of R123's clinical record revealed the following: 12/29/16 - A care plan for the problem of at risk for falls was developed. On 4/11/17 the care plan was revised to include use of a scoop mattress. 8/14/17 at 3:11 PM and 8/15/17 at 9:33 AM - R123's bed was observed to have a regular mattress instead of a scoop mattress as per the care plan. 8/16/17 at approximately 4:00 PM - During an interview with E3 (ADON) the care plan and the lack of a scoop mattress were reviewed. E3 stated she "would look into it." 8/17/17 at approximately 8:00 AM - During a second interview, E3 stated that R123 did have a scoop mattress placed back in April 2017. However, it was determined that because the resident gets out of bed at times without assistance, it would be more of an accident hazard for her, thus it was removed and a regular mattress was put in place. E3 confirmed that the facility failed to revise the care plan to reflect that the scoop mattress was removed. The facility failed to revise the risk for falls care plan when it was determined that a scoop	F 280	Residents residing in the facility whom have mattress in place as fall interventions and are no longer an appropriate intervention are also at risk for the same deficient practice. DIRECTOR OF NURSING/ designee conducted an audit on fall care plans to ensure appropriate mattress interventions specified on care plans are in place and appropriate. C. STAFF DEVELOPMENT COORDINATOR/ designee will in service Unit Managers and House Supervisors that when a indwelling catheter is discontinued a care plan needs to be updated to reflect the changes. STAFF DEVELOPMENT COORDINATOR/ designee will in service Unit Managers and House Supervisors that when an intervention such as a mattress in a fall care plan is changed the care plan needs to be updated. D. DIRECTOR OF NURSING/ designee will audit new admissions with indwelling catheters and existing patients with indwelling catheters if there is a change to ensure that the care plan reflects current status. Auditing will be conducted daily x2 weeks, weekly x2 weeks, and monthly x2 months to ensure substantial compliance. DIRECTOR OF NURSING/ designee will audit fall care plans to ensure appropriate mattress interventions specified on care plans are in place and appropriate. Audit will be conducted weekly x4 weeks, monthly x2 months to ensure substantial compliance.	

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F 280	Continued From page 30 mattress, which continues to be listed on the current care plan, was determined to be a potential accident hazard for R123. Findings were reviewed during the Exit Conference with E1 (NHA), E3 and E4 on 8/17/17 at 7 PM.	F 280	Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans	
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview, observation, review of the clinical record and other facility documentation as indicated, it was determined that the facility failed to provide the necessary treatment and services, consistent with professional standards of practice, to promote the healing of pressure ulcers (PU's) for one (R242) out of 33 stage 2 sampled residents. The facility failed to obtain a	F 314	A. The facility failed to provide the necessary treatment and services, consistent with professional standards of practice, to promote the healing of pressure ulcers. The facility failed to obtain a physician's order for treatment and lacked evidence that treatments were provided for a period of time. R242 was	10/1/17

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F 314	Continued From page 31 physician's order for treatment of R242's buttock PU's and lacked evidence that PU treatments were provided from 8/2/17 when R242 was readmitted from the hospital through 8/8/17. A wound treatment order was obtained on 8/9/17. Findings include: Review of the facility procedure entitled Medication Reconciliation, dated November 2016, stated, "Medication reconciliation is a process for creating a complete and accurate list of a patient's current medications at admission and with each transition of care to ensure medication safety... includes prescription medications, over-the-counter medications, herbal/naturopathic, vitamins, supplements, home remedies... At admission: Review medication list obtained from referral source (hospital...)... Review discrepancies with admitting attending physician for disposition and reconciliation; document orders in the patient's clinical record...". Review of R242's clinical record revealed the following: R242 was admitted to the facility for short term rehabilitation on 7/12/17 after being hospitalized with significant medical conditions. On 7/13/17, R242 was evaluated for two stage 2 PU's that were present on admission. There was one on the R buttock measuring 0.3 x 0.2 cm and another on the L buttock measuring 0.8 x 0.5 cm. Wound treatment orders were started on 7/12/17 with "Vitamins A&D ointment apply to the Sacrum/Buttocks topically every shift for redness/irritation." A physician ordered an additional treatment of cleansing the R and L	F 314	impacted by this deficient practice. Treatment order was obtained for R242 on 8/9 and there is appropriate documentation that the treatment was completed since initiation of treatment order. In order to protect other residents from the same deficient practice the facility will audit residents currently residing in the building who have pressure ulcers to ensure that there is a treatment in place and that appropriate documentation is in place for such treatments. B. Residents residing in the facility, newly admitted residents, and those residents readmitted with pressure ulcers have the ability to be affected. DIRECTOR OF NURSING/ designee conducted an audit on residents currently residing in the facility, newly admitted residents, and those residents readmitted with pressure ulcers to ensure that there is a treatment in place and that appropriate documentation is in place for such treatments. C. STAFF DEVELOPMENT COORDINATOR/Designee will in-service licensed nursing staff/Wound care nurse on reviewing hospital medication reconciliation sheet with facility assigned physician and transcribing approved hospital treatment orders for pressure ulcers to the residents TAR DIRECTOR OF NURSING /designee will in-service licensed nursing staff on completing 24 hour chart checks on newly admitted residents /residents re-admitted	

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F 314	Continued From page 32 buttocks with NSS and covering the PU's with a hydrocolloid dressing daily on Mondays, Wednesdays and Fridays that began on 7/14/17. The facility developed a care plan for the buttock PU's on 7/13/17 with a goal to show signs and symptoms of healing within normal limits of disease. Review of the admission/5 day MDS, dated 7/19/17, coded R242 as having two stage 2 PU's. R242 was coded as being independent in daily decision making. R242 was readmitted to the hospital on 7/29/17 and her PU wound treatment orders were discontinued on 7/30/17. A progress note written by a nurse, dated 8/2/17, stated that R242 was readmitted to the facility at 7 PM. During skin rounds on 8/3/17, R242 continued to have two stage 2 PU's with the R buttock measuring 2.0 x 2.2 cm and the L buttock measuring 0.8 x 0.2 x < 0.1 cm. Review of the Medication Reconciliation Order Sheet written by a hospital physician, dated 8/3/17 (incorrectly dated, should be 8/2/17), stated that vitamin A&D ointment was being applied to the sacrum and buttocks while R242 was hospitalized. On 8/2/17, a physician ordered "Vitamins A & D ointment apply to affected areas topically every shift for eczema." Review of facility physician orders from 8/2/17 through 8/8/17 lacked any PU wound treatment orders. Review of the August TAR revealed lack of PU	F 314	from hospital to validate that orders have been transcribed D. DIRECTOR OF NURSING/Designee will audit residents residing in facility/ new admissions/re-admissions with pressures ulcers/treatment orders to validate that a treatment order and documentation are in place. Audits will be daily x 2 weeks, weekly x 2 weeks and monthly x 2 to ensure substantial compliance. DIRECTOR OF NURSING/Designee will randomly audit 10 resident charts to validate that 24 hour chart check is in place. Audit will be conducted weekly x 4 then monthly x 2 to ensure substantial compliance. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans	

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F 314	Continued From page 33 wound treatment from 8/2/17 through 8/8/17. The locations of administration of vitamin A & D ointment were documented on the TAR as "other", "leg- both", and "arm-both". The TAR lacked evidence that A&D ointment was applied to the buttocks or the buttock PU's. A skin round note, dated 8/9/17, stated the R buttock PU was resolved. The stage 2 L buttock PU measured 2.3 x 3.1 x < 0.1 cm (larger than it was on 8/3/17). Physician orders were written on 8/9/17 for Risamine ointment (Menthol-Zinc Oxide) to be applied to the buttocks every shift. Review of the August TAR from 8/9/17 through 8/14/17 confirmed that PU treatments were completed as ordered. On 8/16/17 at approximately 1:40 PM, wound care was observed with E3 (ADON). The R buttock PU was closed with pink skin. The stage 2 L buttock PU was superficial with two small areas with a band of healthy skin between them. The PU's were each about the size of a small pea. During an interview on 8/16/17 at approximately 2 PM, findings were reviewed with E3 and E4 (staff development nurse). E3 and E4 confirmed there were no PU treatment orders from readmission to the facility on 8/2/17 until a wound treatment order was obtained on 8/9/17. They also confirmed there was no wound treatment provided from 8/2/17 to 8/8/17. On 8/16/17 at approximately 3:25 PM, E3, E4, and E14 (wound care nurse) came to the surveyor with additional information. E14 stated	F 314		

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F 314	Continued From page 34 after seeing E3 do wound care earlier on R242, she realized that she measured the L buttock wound incorrectly on 8/9/17. E14 stated that she included the periarea which made the wound look like it had gotten larger than it actually was. E3 stated the hospital was using A&D ointment to the sacrum and buttocks per the medication reconciliation list and although the facility physician wrote for A&D ointment on 8/2/17 to be applied to affected areas every shift for "eczema", it was applied to the buttock PU's. E3 confirmed there was no documentation of wound care from 8/2/17 through 8/8/17 in the progress notes or the TAR for this timeframe. A progress note, dated 8/16/17 and timed 3:44 PM, stated, "Addendum to previous note: A&D ointment applied to sacrum and buttocks from 08/02/2017 to 08/09/2017 per hospital discharge orders, correction to previously noted wound measurement, the increase in wound measurements includes the measurement of the periwound due to... redness/irritation likely related to use of hydrocolloid treatment...". A skin round note, dated 8/16/17 and timed 4:10 PM, stated that R242's stage 2 L buttock PU measured 1.1 x 1.2 x < 0.1 cm. These notes were written by E14. During an interview on 8/16/17 at approximately 4 PM with E4 and E14, E14 stated that although the A&D ointment treatment, dated 8/2/17 was for "eczema", she did R242's wound treatments with it daily from 8/2/17 through 8/8/17. E14 confirmed there was no evidence of the PU treatments during this time in the clinical record. E4 stated R242 would confirm that wound care was done daily every day during this timeframe and a written statement would be provided.	F 314		

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F 314	Continued From page 35 On 8/16/17 at approximately 4:30 PM, E3 provided a copy of a written statement from R242. The untimed statement, dated 8/16/17, conducted by E3 stated, "(R242) do you remember if anyone did a treatment on your bottom since you returned from the hospital?" R242 stated, "Yes (E14) always does it." E3 then asked "Do you know what she was putting on it?' to which R242 replied "No, I don't know what she was putting on it but she always does." As stated previously, the August TAR revealed that R242 received daily wound treatments from 8/9/17 through 8/14/17 (date MAR was copied). The facility failed to obtain a wound treatment order and failed to have evidence of completed wound treatments to R242's buttock PU's after the resident was readmitted to the facility on 8/2/17 from the hospital through 8/8/17 (7 days). 8/17/17 at approximately 7:00 PM - Findings were reviewed with E1 (NHA), E3 (ADON), E4 (Staff Development Nurse), and E6 (Corporate Quality Assurance Consultant).	F 314		
F 315 SS=E	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 315		10/1/17

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	085028	A. BUILDING _____ B. WING _____	C 08/17/2017

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F 315	Continued From page 36 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews, and review of facility practice guidelines, it was determined that for 3 (R43, R168 and R213) out of 33 Stage 2 sampled residents, the facility failed to ensure that residents who are incontinent of bladder and/or bowel received appropriate treatment and services to restore continence to the extent possible based on the resident's comprehensive assessment. For R213, the facility failed to complete an accurate comprehensive assessment regarding R213's continence status. The facility failed to complete a voiding diary on	F 315	A. The facility failed to ensure that residents who are incontinent of bladder and or bowel received appropriate treatment and services to restore continence to the extent possible based on the comprehensive assessment. R213, R168, and R43 were impacted by this deficient practice. The facility failed to complete an accurate comprehensive assessment regarding continent status. R213 and R168 were impacted by this deficient practice. R213 now has a 3 day bladder diary, urinary	

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F 315	Continued From page 37 admission when R213 was coded as frequently incontinent of bladder and failed again when a decline was noted per the quarterly MDS on 11/10/17 when he was coded as always incontinent of bladder. The facility failed on multiple occasions to accurately and comprehensively assess R213's continence status and failed to develop an individualized toileting plan based on assessed needs. For R43, the facility failed to comprehensively assess R43's urinary incontinence (which included a 3-day voiding diary) after her indwelling catheter was no longer present from 7/2/17 through 8/16/17. For R168, the facility failed to accurately assess R168's urinary continence status, failed to establish an individualized toileting program, and failed to reassess R168's urinary continence after the resident showed a decline on the 7/21/17 quarterly MDS. These failures resulted in R168 not receiving the services necessary to restore continence to the fullest extent possible. Findings include: The facility's Urinary Incontinence Management Practice Guide, dated 3/2012, stated the following: - "...Urinary Incontinence Management Guide is an approach that uses the nursing process framework: assess, plan, implement and evaluate...; - Phase 1: Assess...Initial Evaluation. Review the hospital discharge records, transfer sheets or other data regarding the patient's history of, or risk factors for incontinence. Interview the patient and family...about the patient's history of incontinence and risk factors...Obtain information about bladder patterns and how ADL's and mobility affect these patterns...Complete the Patient Admission/Readmission Screen...Upon	F 315	incontinence CARE AREA ASSESSMENT, identified voiding pattern, and an individualized toileting plan. R168 now has a 3 day bladder diary, urinary incontinence CARE AREA ASSESSMENT, identified voiding pattern, and an individualized toileting plan. The facility failed to complete a voiding diary upon admission when incontinence was coded as a frequently incontinence of bladder. R213 was impacted by this deficient practice. R213 now has a 3 day bladder diary, urinary incontinence CARE AREA ASSESSMENT, identified voiding pattern, and an individualized toileting plan. The facility failed to complete a voiding diary when a decline was noted per quarterly MDS when the patient was coded as always incontinent of bladder. R213 was impacted by this deficient practice. R213 now has a 3 day bladder diary, urinary incontinence CARE AREA ASSESSMENT, identified voiding pattern, and an individualized toileting plan. The facility failed to develop an individualized toileting plan based on assessed needs per quarterly MDS. R213 and R168 were impacted by this deficient practice. R213 now has a 3 day bladder diary, urinary incontinence CARE AREA ASSESSMENT, identified voiding pattern, and an individualized toileting plan. R168 now has a 3 day bladder diary, urinary incontinence CARE AREA ASSESSMENT, identified voiding pattern, and an individualized toileting plan. The facility failed to comprehensively assess urinary incontinence including a 3	

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F 315	Continued From page 38 completion of the Patient Admission/Readmission Screen, the initial plan of care is developed and individualized for the patient...Interventions are monitored for effectiveness and modified as needed...A comprehensive RAI process includes the Minimum Data Set (MDS), the Care Area Assessment (CAA)...The Care Area Assessments use a structured framework to further assess issues identified on the MDS...When creating the comprehensive interdisciplinary care plan to address the patients incontinence symptoms, the interdisciplinary care plan team considers the information contained in the UI CAA summary as well as information contained in other triggered CAAs to fashion a coordinated care approach; - Phase 2: Plan...Comprehensive Care Plan. Based upon the findings of the MDS and other evaluations, the patient's initial plan of care is updated or a comprehensive care plan is developed to include individualized patient interventions...Individualized interventions are selected based upon the patient's type of UI..., past history, functional status and the patient's willingness to participate with the plan of care. It is important to establish care plan goals with input from the patient and family...The care plan is reviewed and updated to reflect the patient's current status and care delivery needs, as clinically indicated...; - Phase 3: Implement...On the basis of information obtained and analysis performed in the assessment and planning phases, the next step is to implement an organized approach for the management of UI...Re-evaluate patients with UI on a regular basis. Implementation of a bladder diary...is important during this stage...A bladder diary is an objective evaluation tool useful in monitoring treatment effectiveness and identifying types of voiding dysfunction and	F 315	day bladder diary after her indwelling catheter was no longer present. R43 was impacted by this deficient practice. R43 now has a 3 day bladder diary, urinary incontinence CARE AREA ASSESSMENT, identified voiding pattern, and an individualized toileting plan In order to protect other residents from the same deficient practice, the facility will initiate a 3 day bladder diary upon admission and with a noted change such as a decline or discontinued indwelling catheter , complete a comprehensive assessment, complete an Urinary Incontinence CARE AREA ASSESSMENT, and develop an individualized toileting plan. B. Residents currently residing in the facility with a decline in urinary continence per most recent MDS have the ability to be impacted by this deficient practice. DIRECTOR OF NURSING/ designee conducted an audit of patients with decline in urinary incontinence on MDS since 8/17/17 to ensure a 3 day bladder diary, urinary incontinence CARE AREA ASSESSMENT, identified voiding pattern, and an individualized toileting plan is in place. Residents who have a discontinued indwelling catheter have the ability to be impacted by this deficient practice. DIRECTOR OF NURSING/ designee conducted an audit of residents who have indwelling catheters that have been discontinued to ensure that a 3 day bladder diary, urinary incontinence CARE AREA ASSESSMENT, identified voiding	

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F 315	Continued From page 39 urinary incontinence...The bladder diary can be utilized to: provide a reference point or baseline of patient's...voiding pattern, provide an objective measurement of the achievement of outcomes, identify the frequency of voiding..., develop individual treatment goals...; - Phase 4: Evaluate...Patients with a change in condition related to their continence status are reviewed by the interdisciplinary team...". The facility's instructions for a Bladder Diary stated, "...complete the 3 day bladder diary on all new admissions, patients with significant change, and any patient who has a change in incontinence status...Unit Manager/shift supervisor is responsible for creating an incontinence care plan and completing an incontinence assessment...". 1. R213's clinical record revealed the following: The hospital History and Physical (H&P), dated 7/29/17, present in R213's facility clinical record, stated "...history of neurogenic bladder, and he does not have a Foley at present, as he is able to sense when he needs to void...". 8/3/16 - A "Receiving Hospital Report" (nurse to nurse report from hospital to LTC facility) stated R213 was continent of bowel and bladder. 8/3/16 - R213 was admitted to the facility with diagnoses that included neurogenic bladder, incomplete quadriplegia and muscle spasms. 8/3/16 - The Patient Admission/Readmission Screen stated R213 had bladder and bowel incontinence and that a care plan would be developed and the intervention to adjust toileting	F 315	pattern, and an individualized toileting plan is in place. Newly admitted patients who are admitted with incontinence have the ability to be impacted by this deficient practice. New admissions have the ability to be impacted by this deficient practice. DIRECTOR OF NURSING/ designee conducted an audit of new admissions since 8/17/17 to ensure that a 3 day bladder diary, urinary incontinence CARE AREA ASSESSMENT, identified voiding pattern, and an individualized toileting plan is in place. C. STAFF DEVELOPMENT COORDINATOR/ designee will in service Unit managers and house supervisors on the Incontinence management guide/ policy/ procedure. STAFF DEVELOPMENT COORDINATOR/ designee will in service CNA's on the policy and procedure of completing bladder diaries. STAFF DEVELOPMENT COORDINATOR/ designee will in service Unit mangers on Incontinence CARE AREA ASSESSMENT, developing a toileting plan, care planning and initiation of bladder diaries on all new admissions, and patients with a change in urinary continence. STAFF DEVELOPMENT COORDINATOR/ designee will in service MDS to report patients that have triggered for changes in urinary continence daily in ER. D. DIRECTOR OF NURSING/ designee	

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F 315	Continued From page 40 times to meet patient needs would be included. The facility failed to complete a 3 Day Bladder Diary, and Urinary Incontinence assessment at this time. The facility failed to identify voiding patterns and failed to develop an individualized toileting plan for R213. 8/4/16 - A care plan was developed for the problem "Functional urinary incontinence related to loss of bladder muscle tone, and impaired mobility." Interventions included the following: - adjust toileting times to meet needs; - at established toileting times ask if toileting is needed and remind that it is time to use toilet (noted resolved on 5/19/17); - identify voiding patterns and establish toileting program (noted resolved on 12/7/16); - inform of next scheduled toileting time (noted resolved on 12/7/16); - place urinal/bedpan within resident's reach (noted resolved 12/26/16); - provide assistance with toileting; - provide incontinent care as needed. 8/4/16 - An OT Evaluation & Plan of Treatment stated, "...is transferred on/off toilet by standing lift...". 8/5/16 - An OT Evaluation & Plan of Treatment was completed. The patient goal stated, "...would like to feed himself and be able to stand up/increase independence with toileting...Toileting...is able to feel the sensation he needs to urinate and have a bowel movement but is TD (totally dependent) for hygiene and clothing mgmt (management)...". 8/5/16 - A PT Evaluation & Plan of Treatment	F 315	will audit new admissions daily x2 weeks, weekly x2 weeks, and monthly x2 months to ensure that there is a 3 day bladder diary, urinary incontinence CARE AREA ASSESSMENT, identified voiding pattern, and an individualized toileting plan is in place to ensure substantial compliance. DIRECTOR OF NURSING/ designee will audit patients who have a decline in MDS related to urinary continence per quarterly review to ensure that 3 day bladder was initiated, a comprehensive assessment was completed, a Urinary Incontinence CARE AREA ASSESSMENT was completed and that an individualized toileting plan was developed. Audit will be conducted daily x2 weeks, weekly x2 weeks, and monthly x 2 months to ensure substantial compliance. DIRECTOR OF NURSING/ designee will audit via the 24 hour report for changes such as discontinued indwelling catheters and the need to initiate a 3 day bladder, a comprehensive assessment, Urinary Incontinence CARE AREA ASSESSMENT, and develop an individualized toileting plan. Audit will be conducted daily x2 weeks, weekly x2 weeks, monthly x2 months to ensure substantial compliance. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	

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F 315	Continued From page 41 stated one of R213's long term goals was to be able to roll side to side in bed with minimum assist in order to prepare for use of a bedpan and participate in self care activities. 8/10/16 - The admission MDS assessment stated R213 was cognitively intact, and required extensive assistance of 2 staff for bed mobility, transfers and toilet use. The MDS assessment also stated that R213 was frequently incontinent of bladder and always incontinent of bowel and there was no toileting program being used to manage either bowel or bladder incontinence. 10/24/16 - An OT Discharge Summary stated R213's goal to increase ability to stand supported for 1-3 minutes in order to increase participation with ADL tasks was met. 10/24/16 - A PT Discharge Summary stated R213's sitting balance was "fair" (able to maintain balance unsupported without loss of balance or upper extremity support), and the goal to roll side to side in bed with moderate assist in order to prepare for use of a bedpan was met on 9/7/16. 11/10/16 - A quarterly MDS assessment stated R213 was cognitively intact, required extensive assistance of one (1) staff for bed mobility, dressing, toilet use and hygiene, and required extensive assistance of two (2) staff for transfers. The MDS stated R213 was always incontinent of bladder and bowel and there was no toileting program being used to manage either bowel or bladder incontinence. Despite the decline of bladder continence from frequently incontinent (8/10/16 MDS) to always incontinent (11/10/16 MDS), the facility failed to re-assess R213's continence status, did not complete a 3 day	F 315		

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F 315	Continued From page 42 bladder diary nor a urinary incontinence assessment 1/16/17 - A 3 Day Bladder Diary was completed which documented that R213 was incontinent of bladder at all times. 1/19/17 - A Urinary Incontinence assessment was completed which stated R213 had functional incontinence (can't get to toilet in time due to physical disability, external obstacles, or problems thinking or communicating). 1/19/17 - A progress note stated, "Urinary Incontinence...Evaluation has been completed...Comments: Resident noted with functional incontinence with no identifiable pattern based on the three-day bladder diary. Resident has a diagnosis of quadriplegia, muscle spasm, neuromuscular bladder dysfunction [neurogenic bladder]...Resident is most appropriate for and will be placed on scheduled toileting program." 1/19/17 - The urinary incontinence care plan was revised to include the intervention "Scheduled Toileting Plan: assist with toileting upon rising, before/after meals, at bedtime and as needed. 2/2/17 - A neurology consult stated, "...residual incomplete quadriplegia...currently in a wheelchair, able to pivot, use walker with assist...is aware of need to have bladder or bowel movement but uses depends mainly due to time constraint...". 2/10/16 - A quarterly MDS assessment stated R213 was cognitively intact, was totally dependent on 2 staff for bed mobility, required extensive assistance of 2 staff for transfers, and	F 315		

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F 315	Continued From page 43 required extensive assistance of one (1) staff for toilet use. The MDS stated R213 was always incontinent of bowel and bladder and there was no toileting program being used to manage the incontinence. 5/13/17 - A quarterly MDS assessment stated R213 was cognitively intact, required extensive assistance of 2 staff for bed mobility and transfer, and was totally dependent on 2 staff for toilet use. The MDS stated R213 was always incontinent of bowel and bladder and there was no toileting program being used to manage the incontinence. 7/17/17 - A Rehabilitation Screening was completed and stated that R213 was a one person assist with transfers. However, a stand up lift may be used on occasion. 8/10/17 2:26 PM - During an interview, R213 was asked if he gets the help he needs being toileted? R213 stated that at times they are short staffed and by the time they get to him he will have to go in the brief, or that the stand up lift is in use and they only have one. R213 stated when asked, that they have not tried using a urinal with him and that he usually waits till the end of the day to tell them he is wet. R213 stated that if he asks sooner, they will try to put him to bed and then don't always want to get him back up. R213 stated he doesn't want to be in bed for the night starting at 5:30 PM. 8/15/17 approximately 12:00 PM - During an interview, E27 (RN) stated that on admission all residents are to have a 3 day bladder diary completed, then the urinary assessment is completed and based on those two results the resident is placed on a toileting program when	F 315		

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F 315	Continued From page 44 appropriate. 8/17/17 10:30 AM - During an interview, E28 (Rehabilitation Director) stated that when R213 was first admitted to the facility he required a Hoyer lift for transfers, was unsteady with sitting balance and it would not have been ideal to have him sit on a commode. E28 stated he had screened him on 7/27/17 and that he was a one (1) person transfer, but depending on the day and how the resident was feeling, he may require a stand up lift. 8/17/17 approximately 10:35 AM - In an interview with E29 (RNAC) she stated that the facility's MDS electronic program did not warn them that a bladder continence decline had occurred for R213 from the admission MDS (8/10/16) when he was frequently incontinent to the quarterly MDS (11/10/16) when he was always incontinent of bladder. E29 stated that any resident declines are presented in morning meeting and discussed. E29 stated she would look for any notes she might have regarding this decline. However, no notes were provided to the surveyor. 8/17/17 11:00 AM - During an interview, E15 (CNA) confirmed she worked regularly with R213. E15 stated that when first admitted he required Hoyer transfers and resided on the second floor. E15 stated R213 was transferred down to the first floor sometime in December 2016 and he has "come a long way." E15 stated R213 is now able to wash his face, brush his teeth and approximately two (2) months ago they started using the stand up lift. E15 stated that last week they began getting him on the toilet to have bowel movements (BM) and that he lets them know when he needs to go. E15 stated that when	F 315		

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F 315	Continued From page 45 asked about needing to urinate he always states he is okay and that when she once gave him the urinal he was not able to hold it in place properly and stated he was okay and declined her assistance. E15 stated that he only tells them when he needs to have a BM, not when he needs to urinate. 8/17/17 11:45 AM - During a second interview with R213, he was again asked if he was toileted when necessary. R213 stated that when E15 was his CNA, most of the time he is, however, "others take too long" and by the time they get to him it's too late. R213 stated they started to use the stand up lift approximately a month ago. R213 stated he is aware of when he needs to have a BM, but when he needs to urinate he goes in his brief "because it takes the staff too long most times to get to him and when they get to him it's already started." R213 also stated he feels there was not enough staff available. When asked if the staff are toileting him around scheduled times, he stated they were totally relying on him to let them know when he needs to have a BM or when he needs changing. R213 stated that he has been using a brief since the onset of the quadriplegia and that he is aware, but because assitance is inconsistent he wears a brief. R213 stated that it was "embarrassing." When asked if anyone in the facility has had a discussion with him regarding a scheduled toileting program, he stated "Other than you, no one has." R213 stated that he would like to participate in a scheduled toileting program. The facility failed to complete an accurate comprehensive assessment regarding R213's continence status. The facility failed to complete a voiding diary on admission when R213 was	F 315		

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F 315	Continued From page 46 coded as frequently incontinent of bladder and failed again when a decline was noted per the quarterly MDS on 11/10/17 when he was coded as always incontinent of bladder. The facility failed to accurately and comprehensively assess R213's continence status and failed to develop an individualized plan toileting based on assessed needs for bowel and bladder continence. 8/17/17 approximately 2:20 PM - Findings were reviewed with E1 (NHA), E3 (ADON), E4 (Staff Dvelopment RN), and E6 (Corporate Quality Assurance Consultant). At 2:35 PM E3 stated that the reason R213 had the 1/19/17 three (3) day voiding diary completed was because they (the facility) identified that bladder diaries weren't being completed as per facility procedures. E3 stated they went through all records, identified the residents who needed them done and then completed them. 2. Review of R43's clinical record revealed the following: R43 had a diagnosis of a neurogenic bladder and the usage of a foley catheter. 4/15/16 - R43 was care planned for an urinary catheter due to neurogenic bladder with interventions that included: change catheter per physician order...report to physician signs of UTI... report any changes in amount and color or odor of urine. 4/15/16 - R43 was care planned for being at risk for urinary incontinence despite the presence of a urinary catheter for neurogenic bladder related to bladder spasms and spontaneous catheter expulsion. The goal was for R43 was to be	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING _____ B. WING _____	C 08/17/2017

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F 315	Continued From page 47 maintained as clean and dry as possible. Approaches included: ...provide incontinence care as needed...report changes in amount, frequency, color or odor of urine...use absorbent products as needed. 11/24/16 - A physician's order stated to change R43's foley catheter as needed for leakage and blockage. 11/30/16 - A physician's order stated to maintain a foley catheter for R43 on every shift. Review of R43's July 2017 eTAR revealed the following: - from 7/2/17 through 7/26/17, licensed nursing staff were signing off that R43's foley catheter was being maintained on 53 out of 75 shifts, while 22 shifts stated that R43 did not have a foley catheter; - from 7/27/17 through 7/31/17, a hold was placed on maintaining R43's foley catheter every shift. On 7/29/17 at 11:51 AM, a progress note stated that R43's foley catheter was patent. This progress note contradicted R43's 7/29/17 eTAR entry which stated that R43's foley catheter was on hold. Review of R43's clinical record revealed a lack of evidence that R43's foley catheter was reinserted from 7/2/17 through 7/31/17. It was unclear from R43's record to determine the exact time when R43's foley catheter came out, how the facility responded, which included notifying the physician immediately to determine if additional interventions were needed, and how the facility was monitoring R43's change in urinary status. The facility failed to identify when R43's foley	F 315		

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F 315	Continued From page 48 catheter came out, notify the physician immediately, comprehensively assess R43's change in urinary status in order to update and individualize her plan of care according to her current urinary incontinence needs. 7/8/17 - The quarterly MDS assessment stated that R43 was cognitively intact, required extensive assistance of 2 staff for toileting and bed mobility, used a foley catheter and was always incontinent of urine. It was unclear why the facility coded that R43 had a foley catheter when the clinical record contradicted this information. Review of R43's August 2017 eTAR revealed the following: - from 8/1/17 through 8/16/17, a hold was placed on maintaining R43's foley catheter every shift. Despite the hold on R43's urinary catheter, review of R43's progress notes from 8/1/17 through 8/16/17 revealed the following: - on 8/10/17 at 2:39 PM, a progress note stated that R43's foley was draining well; - on 8/12/17 at 3:08 PM, a progress note stated that R43's foley catheter was patent with no discomfort. It was unclear how licensed nursing staff were monitoring R43's urinary status when the foley catheter was on hold. 8/16/17 - Review of R43's CNA Kardex for bowel and bladder care needs revealed the following: catheter care, briefs, and to provide incontinent care as needed. The facility failed to update and individualize R43's plan of care to address her current urinary incontinence needs. 8/16/17 at 11:23 AM - During an interview, R43	F 315		

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F 315	Continued From page 49 stated that she does not have a foley catheter because "her body keeps pushing the foley's out due to muscle spasms". R43 stated that she thought she was on a 2-hour check and change schedule, but that was not occurring as she had recently filed a grievance due to lack of timely incontinence care. 8/16/17 at 5:27 PM - During an interview, E24 (CNA) stated that she was very familiar with R43 and her care needs. E24 stated that she could not remember the exact date, but R43 had not had a foley since around June 2017. 8/17/17 at 9:01 AM - During an interview, when E3 (ADON) was asked if the facility had any voiding diaries for R43, E3 stated that R43 had a foley and does not have any voiding diaries. The surveyor informed E3 that R43 does not have a foley catheter. 8/17/17 at 9:26 AM - During a follow-up interview with E3 and E4 (Staff Development RN), R43's clinical record was reviewed. E3 and E4 confirmed that the facility failed to identify the absence of the foley, failure to notify the physician immediately to determine if further interventions were needed, comprehensively assess R43's urinary status in the absence of the foley to determine an individualized plan of care, update the care plan and the CNA Kardex and document accurately in R43's eTAR and progress notes from 7/2/16 through 8/12/17. Findings were reviewed during the Exit Conference with E1 (NHA), E3 and E4 on 8/17/17 at 7 PM. From 7/2/17 through 8/16/17, the facility failed to do the following: - identify when R43's foley catheter was no longer	F 315		

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F 315	Continued From page 50 present; - notify the physician immediately when R43's foley catheter was no longer present to determine if further interventions were needed; - comprehensively assess R43's urinary status, including initiating a 3-day voiding diary, to determine an individualized plan of care when R43's urinary status changed; - accurately code that R43 did not have a foley catheter on the 7/8/17 quarterly MDS; - update R43's urinary incontinence care plan and the CNA Kardex to address her current needs; and - document accurately in R43's eTAR and progress notes with respect to her current urinary status. 3. Review of R168's clinical record revealed the following: R168 was admitted to the facility on 4/13/17 with diagnoses that included amputation of both legs below the knee. 4/14/17 through 4/16/17- A three-day Bladder Diary was completed and revealed that R168 was incontinent of urine on six (6) out of eighteen (18) occasions and continent of urine on twelve (12) out of eighteen (18) occasions. 4/14/17 through 4/16/17- The CNA's electronic Documentation Survey Report stated that R168 was incontinent of urine on thirteen (13) occasions and continent of bladder on three (3) occasions. The three-day Bladder Diary and the electronic Documentation Survey Report had conflicting documentation. 4/14/17- R168 was care planned for functional	F 315		

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F 315	Continued From page 51 incontinence related to impaired mobility, loss of bladder muscle tone, and urge incontinence. The approaches included: to identify a voiding pattern and establish toileting program, inform the resident of the next scheduled toileting time, provide assistance with toileting, place urinal/bedpan within resident's reach, and remind and assist as needed with toileting at routine times such as upon arising in the morning, before/after meals, activities, therapy, and at bedtime. There was no evidence that the facility established an individualized toileting program for R168's urinary incontinence based on assessments and resident needs. 4/20/17- The admission MDS stated that R168 was independent for daily decision making and that an extensive assist of one (1) staff was required for transfers and toilet use. The MDS also stated R168 was frequently incontinent of bladder during the seven (7) day review period and a trial toileting program was not attempted on admission or since urinary incontinence was noted in this facility. 7/21/17- The quarterly MDS stated that R168 was independent for daily decision making and that an extensive assist of one (1) staff was required for toilet use and two (2) staff were required for transfers. The MDS also stated that R168 declined to always incontinent of bladder during the seven (7) day review period and a trial toileting program was not attempted. After the resident declined from frequently incontinent of urine to always incontinent of urine per policy a three-day bladder diary was to be completed. There was no evidence of a bladder diary being completed after R168's urinary	F 315		

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F 315	Continued From page 52 incontinence declined on 7/21/17. During an interview on 8/15/17 at approximately 11:30 AM, E15 (CNA) stated that R168 called staff when she was wet and needed to be changed. When the surveyor asked if the resident was on a toileting program, E15 stated that all residents are on a toileting program to toilet every 2 hours, but that R168 was incontinent. During an interview with E2 (DON) on 8/15/17 at approximately 3:00 PM it was confirmed that a bladder diary was not completed after 7/21/17. During an interview with R168 on 8/16/17 at 2:15 PM, the surveyor asked R168 if she was aware when she needed to urinate and R168 stated yes. The surveyor asked R168 if she was able, with staff assistance, to use a commode or toilet and the resident stated no, that she does not have legs. The surveyor asked R168 if she was ever told about a toileting schedule or ever offered a bed pan. R168 stated no, that she did not have a toileting schedule because she used a diaper and she had not used a bed pan. R168 stated that she felt there was no difference between using a diaper and using a bed pan. Review of the clinical record revealed that the facility failed to accurately assess R168's urinary continence status, failed to establish an individualized toileting program, and failed to reassess R168's urinary continence after the resident showed a decline on the 7/21/17 quarterly MDS. These failures resulted in R168 not receiving the services necessary to restore continence to the fullest extent possible. Findings were reviewed and confirmed with E1	F 315		

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F 315	Continued From page 53 (NHA) and E6 (Corporate Quality Assurance Consultant) on 8/16/17 at approximately 3:20 PM.	F 315		
F 353 SS=D	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of	F 353		10/1/17

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F 353	Continued From page 54 duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that for 2 (R43 and R213) out of 33 Stage 2 sampled residents, the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and individual plans of care. For R43, the facility failed to respond appropriately and timely when she requested incontinence care. The facility failed to have qualified staff in sufficient numbers to provide necessary care and services on a 24-hour basis, based upon the comprehensive assessment and care plan for R213. Findings include: 1. Review of R43's clinical record revealed the following: 7/8/17 - The quarterly MDS assessment stated that R43 was cognitively intact, required extensive assistance of 2 staff for toileting and bed mobility, and was always incontinent of urine.	F 353	A. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnosis of the facility's resident population in accordance with the facility assessment required. The facility failed to respond appropriately and timely when R43 requested incontinence care. R43 was impacted by this deficient practice. R43 is being met with weekly to validate that call bell response/toileting needs /incontinence care are met timely. The facility failed to have qualified staff in sufficient numbers to provide necessary care and services on a 24 hour basis, based upon the patient's comprehensive assessment and care plan. R213 was	

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F 353	Continued From page 55 8/13/17 - The facility's Concern Form, completed and submitted to the facility by R43, stated, "8/13/17...CNA 7 to 3. On Sunday I put my light on 3x's to be changed. (E26, CNA) said, 'I'm waiting for (another CNA name) to finish so she can help change me.' That was @ 1:45 pm & again at 2:10 pm. (E26) NEVER came back to change me! My last change was @ 11:30 am...I was soaked when (E24, CNA) got to me at 3:00 pm!" 8/16/17 at 11:23 AM - During an interview, R43 stated that she thought she was on a 2-hour check and change schedule, but that was not occurring as she had recently filed a grievance due to the lack of timely incontinence care. R43 stated that on Sunday, 8/13/17, she put her call light on at approximately 1:45 AM as she was incontinent of urine. E26 (CNA) responded to the call light and told R43 that she was waiting for another CNA to help her. R43 stated that E26 never returned. R43 stated that she fell asleep and woke up at the beginning of the 3 PM to 11 PM shift when E24 (CNA) came in to check on her. Approximately 1.25 hours later, R43 stated that she told E24 about being incontinent and how E26 never returned to her room after she asked for incontinent care. R43 stated that she apologized to E24, who immediately provided incontinence care. 8/16/17 at 5:27 PM - During an interview, E24 confirmed R43's statement above. E24 stated that she changed her immediately as R43 was soaked with urine. 8/17/17 at 9:26 AM - During an interview, E3 (ADON) and E4 (Staff Development RN)	F 353	impacted by this deficient practice. R213 is being met with weekly to validate that toileting needs are met timely to include use of urinal, he is being toileted at or around scheduled toileting times, and that the sit to stand lift is readily available for his use when needed. B. Patients currently residing in the facility that require assistance for toileting and incontinence care have the ability to be impacted by this deficient practice. DIRECTOR OF NURSING/ designee conducted random auditing of residents that require assistance for toileting to validate that needs are met timely. Patients currently residing in the building that require use of the sit to stand lift for toileting have the ability to be impacted by this deficient practice. DIRECTOR OF NURSING/ designee conducted random auditing of residents requiring the use of the lift for toileting to ensure that the lift is available timely for use to be toileted. C. STAFF DEVELOPMENT COORDINATOR/Designee will in-service staff to answer call lights timely, directing clinical needs to assigned nursing staff, and fulfilling non-clinical requests themselves. STAFF DEVELOPMENT COORDINATOR/ designee will in-service nursing staff on answering call lights timely and responding to needs such as toileting timely. STAFF DEVELOPMENT COORDINATOR/designee will in-service nursing staff/ therapy staff that when the	

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F 353	Continued From page 56 acknowledged the findings. The facility failed to have sufficient nursing staff to respond appropriately and timely to R43's request for incontinence care. Findings were reviewed during the Exit Conference with E1 (NHA), E3 and E4 on 8/17/17 at 7 PM. 2. Cross refer to F315, example #1 R213's clinical record revealed the following: The hospital History and Physical (H&P), dated 7/29/17, present in R213's facility clinical record, stated "...he is able to sense when he needs to void...". 8/3/16 - A "Receiving Hospital Report" (nurse to nurse report from hospital to LTC facility) stated R213 was continent of bowel and bladder. 8/3/16 - R213 was admitted to the facility with diagnoses that included neurogenic bladder, incomplete quadriplegia and muscle spasms. 8/3/16 - The Patient Admission/Readmission Screen stated R213 had bladder and bowel incontinence and that a care plan would be developed and the intervention to adjust toileting times to meet patient needs would be included. 8/4/16 - A care plan was developed for the problem "Functional urinary incontinence related to loss of bladder muscle tone, and impaired mobility." Interventions included the following: - adjust toileting times to meet needs; - at established toileting times ask if toileting is needed and remind that it is time to use toilet	F 353	sit to stand lift is not actively in use, to return it to the storage area for use of other residents. STAFF DEVELOPMENT COORDINATOR/ designee will in-service nursing staff on following scheduled toileting times outlined for residents per their individual toileting care plan. In order to protect other residents in similar situations the facility will conduct daily staffing meetings to validate that mandated PPD is met and sufficient staff present to meet the resident's needs on a 24 hour basis. The Staff Development Coordinator/ designee will conduct in servicing to CNA's regarding timely response to call lights. The facility will establish a storage area for the sit to stand lift when it is not being utilized so that it will be readily available to staff for patient use timely. D. DIRECTOR OF NURSING/ Designee will randomly audit 10 residents weekly then monthly, that require staff assistance for toileting to validate that needs are met timely and that residents are not urinating or defecating in briefs as the cannot get to the bathroom in time. Auditing will be conducted weekly x4 weeks and monthly x 2 months to ensure substantial compliance. DIRECTOR OF NURSING/designee will randomly audit 10 residents weekly then monthly, that require assistance with toileting needs to validate that residents are being toileted at or around scheduled toileting times. Auditing will be conducted weekly x 4 weeks and monthly x 2 months	

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F 353	Continued From page 57 (noted resolved on 5/19/17); - identify voiding patterns and establish toileting program (noted resolved on 12/7/16); - inform of next scheduled toileting time (noted resolved on 12/7/16); - place urinal/bedpan within resident's reach (noted resolved 12/26/16); - provide assistance with toileting; - provide incontinent care as needed. 8/4/16 - An OT Evaluation & Plan of Treatment stated, "...is transferred on/off toilet by standing lift...". 8/5/16 - An OT Evaluation & Plan of Treatment was completed. The patient goal stated, "...be able to stand up/increase independence with toileting...Toileting...able to feel the sensation he needs to urinate and have a bowel movement...". 8/5/16 - A PT Evaluation & Plan of Treatment stated one of R213's long term goals was to be able to roll side to side in bed with minimum assist in order to prepare for use of a bedpan and participate in self care activities. 8/10/16 - The admission MDS assessment stated R213 was cognitively intact, and required extensive assistance of 2 staff for bed mobility, transfers and toilet use. The MDS assessment also stated that R213 was frequently incontinent of bladder and always incontinent of bowel and there was no toileting program being used to manage either bowel or bladder incontinence. 10/24/16 - An OT Discharge Summary stated R213's goal to increase ability to stand supported for 1-3 minutes in order to increase participation with ADL tasks was met.	F 353	to ensure substantial compliance. DIRECTOR OF NURSING/ designee will randomly audit 5 residents weekly then monthly, that require use of the sit to stand lift for toileting to ensure that the lift is available and used timely when requesting to be toileted. Auditing will be conducted weekly x 4 weeks and monthly x 2 months to ensure substantial compliance. DIRECTOR OF NURSING/ designee will validate through monthly resident council meetings that resident's toileting needs are being met timely, and the sit to stand lift is available timely. The audit will be conducted will be conducted monthly x 2 months to ensure substantial compliance. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans..	

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MANORCARE HEALTH SERVICES - WILMINGTON	700 FOULK ROAD WILMINGTON, DE 19803

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F 353	Continued From page 58 10/24/16 - A PT Discharge Summary stated R213's sitting balance was "fair" (able to maintain balance unsupported without loss of balance or upper extremity support), and the goal to roll side to side in bed with moderate assist in order to prepare for use of a bedpan was met on 9/7/16. 1/19/17 - The urinary incontinence care plan was revised to include the intervention "Scheduled Toileting Plan: assist with toileting upon rising, before/after meals, at bedtime and as needed. 2/2/17 - A neurology consult stated, "...is aware of need to have bladder or bowel movement but uses depends mainly due to time constraint...". 7/17/17 - A Rehabilitation Screening was completed and stated that R213 was a one person assist with transfers. However, a stand up lift may be used on occasion. 8/10/17 2:26 PM - During an interview, R213 was asked if he gets the help he needs being toileted? R213 stated that at times they are short staffed and by the time they get to him he will have to go in the brief, or that the stand up lift is in use and they only have one. R213 stated when asked, that they have not tried using a urinal with him and that he usually waits till the end of the day to tell them he is wet. R213 stated that if he asks sooner, they will try to put him to bed and then don't always want to get him back up. R213 stated doesn't want to be in bed for the night starting at 5:30 PM. 8/17/17 11:45 AM - During a second interview with R213, he was again asked if he was toileted when necessary. R213 stated that when E15 was	F 353		

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F 353	Continued From page 59 his CNA, most of the time he is, however, "others take too long" and by the time they get to him it's too late. R213 stated he is aware of when he needs to have a BM, but when he needs to urinate he goes in his brief "because it takes the staff too long most times to get to him and when they get to him it's already started." R213 also stated he feels there was not enough staff available. When asked if the staff are toileting him around scheduled times, he stated they were totally relying on him to let them know when he needs to have a BM or when he needs changing. R213 stated that he is aware, but because assitance is inconsistent he wears a brief. R213 stated that it was "embarrassing." The facility failed to have qualified staff in sufficient numbers to provide necessary care and services on a 24-hour basis, based upon the comprehensive assessment and care plan, to assure, maintain and provide continence care for R213. 8/17/17 approximately 7:00 PM - Findings were reviewed with E1 (NHA), E3 (ADON), E4 (Staff Dvelopment RN), and E6 (Corporate Quality Assurance Consultant).	F 353		
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 371		10/1/17

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F 371	Continued From page 60 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure proper handwashing and storage of food to prevent contamination. Findings include: During a kitchen visit on 8/10/17 at 10:55 AM, E12 (Cook) was observed performing handwashing, drying her hands with a paper towel and turning off the faucet with the same paper towel. She then wiped the sides of the sink with same paper towel and patted one hand dry with the paper towel. On 8/10/17 at 11:10 AM, E13 (Cook) was observed performing handwashing, after which he dried his hands with a paper towel. E13 then turned off the faucet using the paper towel and then wiped the sides of the sink using the same paper towel. During a kitchen inspection on 8/16/17 at 3:35 PM, a large bin containing thickener was	F 371	A. In order to protect residents in similar situations, the sides of the sink were cleaned with appropriate cleaning product. The thickener in the storage bin was disposed of, the Storage bin was appropriately cleaned and a new batch of thickener was poured in the storage bin, and storage bin was fully covered. B. The Dietary Director/ designee will conduct audits of Dietary Employee's during handwashing to ensure paper towel was not being used to wipe sink. If deficient practice is noted, sink will be cleaned with appropriate cleaning product. The Dietary Director/ designee audited Storage bins in the kitchen to ensure bins were fully covered as residents residing in the facility have the ability to be impacted. Contents of any uncovered storage bins will be replaced after appropriate cleaning	

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F 371	Continued From page 61 observed to be covered one-third of the way by its lid, leaving the thickener exposed. These findings were reviewed with E1 (NHA) and E3 (ADON) on 8/17/17 at 7:00 PM.	F 371	of storage bin in the kitchen. C. Dietary employees were not identified as wiping the sink with their paper towel after washing their hands. The Storage bin in Kitchen had not been identified as being 1/3 open. Detailed below are the measures the facility will take and the system changes to ensure the problem does not recur. It is the practice of this facility to store, prepare, distribute, and serve food under sanitary conditions. Employee's handwashing in the kitchen will randomly be checked to ensure a paper towel is not used to wipe the sink. Storage Bins in the kitchen will randomly be checked to ensure they are fully covered. The Staff Development Coordinator/ Designee will in-service dietary staff to refrain from using a paper towel, after handwashing, to wipe sink and to ensure kitchen storage bins are fully covered. D. Dietary Director or designee will conduct an audit of employees paper towel use after handwashing to ensure it is not being used to wipe sink, as well as an audit of kitchen storage bins to ensure they are fully covered 5x for one week, then weekly for 3weeks, then if appropriate monthly for 2 months to ensure substantial compliance.	

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F 371	Continued From page 62	F 371	Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	
F 372 SS=D	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that the outdoor garbage dumpster was maintained to prevent access and harborage by insects and rodents. Findings include: On 8/10/17 at 8:30 AM, the garbage dumpster outside the building was observed to be filled with bundles of trash bags and without cover. On 8/15/17 at 1:20 PM, the garbage dumpster was observed to be full of bagged trash and uncovered. On 8/15/17 at 5:00 PM, the garbage dumpster was observed to be full of bagged trash and uncovered. These findings were reviewed with E1 (NHA) and E3 (ADON) on 8/17/17 at 7:00 PM.	F 372	A. Garbage dumpster lid was closed. In order to protect residents in similar situations, the facility will continue to check the dumpster to ensure lid is covering the trash. B. Maintenance Director/ Designee will conduct dumpster area rounds to evaluate whether the facility is maintaining garbage dumpster to prevent access and harborage by insects and rodents. Any findings will be addressed as residents residing in facility have ability to be impacted. C. The Garbage dumpster lid was not identified as being uncovered during the annual survey. Detailed below is the system change and monitoring the facility will do in order to ensure the problem does not recur and solutions are sustained. It is the practice of this facility to maintain garbage dumpster to prevent access and	10/1/17

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F 372	Continued From page 63	F 372	harborage by insects and rodents. The maintenance director/ designee will perform random weekly audits by visualizing garbage dumpster to evaluate compliance. Staff development coordinator/ Designee will in-service staff Dietary and Housekeeping staff to ensure the lid to garbage dumpster is closed and covering the trash. D. Maintenance Director /designee will perform audit of Garbage dumpster 5x for one week, then weekly for 3 weeks, and if appropriate, monthly for 2 months to ensure substantial compliance. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	
F 412 SS=D	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:	F 412		10/1/17

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F 412	Continued From page 64 (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure that dental services were obtained for one (R227) out of 33 Stage 2 sampled residents regarding dentures. Findings include: Review of R227's record revealed: On 2/7/17 at 1:22 PM, a progress note was written by the nutrition department as 'follow up dentition'. "Spoke with resident's son regarding dentition and assistance with dental care and services. Resident's son aware that patient is edentulous. Resident's son would like assistance with dental care and services for having resident fitted for a new set of dentures." On 2/8/17 at 12:30 PM, a progress note was written by a nurse that a dental office was notified of a new order for a dental consult.	F 412	A. The facility failed to ensure that dental services were obtained and followed through. R227 was impacted by this deficient practice. R227 was placed on the dental list for follow up for new dentures. The facility has contacted Kirkwood Dental, in order to follow up on receipt of patient's new dentures. In order to protect residents in similar situations, facility will call appropriate dental provider with each request for dental care and services. The facility will keep a tracking binder that will be maintained by Social Services dept. or designee. B. Residents residing in the facility have the ability to be impacted by this deficient practice. DIRECTOR OF NURSING/Designee will audit current residents who have an order written to	

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F 412	Continued From page 65 On 2/14/17 at 1:28 PM, a progress note was written by a nurse that paperwork was faxed to a dental office for a dental consult. On 2/22/17 at 11:09 AM, a progress note was written by a nurse that there was a new order for a dental consult; POA made aware. There is an undated physician progress note signed by a dentist that stated, "Chief complaint: Dental-Replace missing upper full denture...Preliminary impression taken. Impression/Plan: Will return for final impression and...next week". On 8/16/17 at approximately 4:00 PM, the facility reported that they verified with the dentist that the date of the dental visit was 3/9/17. Review of an admission MDS, dated 2/13/17, and a quarterly MDS, dated 5/16/17 indicated there were no natural teeth or tooth fragments. Observations of R227 made on : 8/10/17 at 2:00 PM 8/14/17 at 11:30 AM 8/15/17 at 12:50 PM revealed that she had no teeth. R227 was interviewed on 8/15/17 at 12:50 PM. R227 stated she does not have any teeth and her food is chopped up so she is able to eat it. R227 stated she did not remember seeing a dentist, but she would like to have dentures. E7 (Social Services Director) was interviewed on 8/15/17 at 2:00 PM regarding the process for dental care. E7 stated that if nursing or dietary have a dental concern they contact the dentist	F 412	receive dental services for dentures within the last 90 days to ensure that services have been provided and that are appropriately followed up on. C. STAFF DEVELOPMENT COORDINATOR/Designee will educate social services department on the need to contact the dentist, follow up until the dentures arrive/ dental concern is resolved, and document. STAFF DEVELOPMENT COORDINATOR/ designee will inservice Social services on the need to maintain the dental log to ensure patients have been consulted and that services are complete. D. DIRECTOR OF NURSING/ designee will audit residents whom require assistance with dental care and services for dentures via the 24 hour report. The audit will be conducted daily x 2 weeks, weekly x2 weeks, and monthly x2 months to ensure substantial compliance. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	

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F 412	Continued From page 66 directly for a consult. E7 stated routine care for long term residents is done by a mobile dental service, but she is unsure of the schedule. E8 (nurse supervisor, LPN) was interviewed on 8/15/17 at 3:20 PM regarding the process for dental care. E8 stated that if a resident has a dental concern she will contact a dentist at a dental office for a consult. E8 stated if a physician writes an order for a cleaning, she will contact the mobile dental service. E8 stated the mobile dental service does not write a note, but the nurse documents the visit in the resident's progress notes. E8 was unable to produce any documentation that R227 had a follow up dental visit for her dentures. Findings were reviewed with E1 (NHA) and E6 (Corporate QA Consultant) on 8/16/17 at 3:20 PM. For more than 5 months the facility failed to follow through with dental services to obtain dentures for R227 and ensure that dental services were provided.	F 412		
F 465 SS=D	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas,	F 465		10/1/17

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F 465	Continued From page 67 and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a kitchen environment that ensured staff safety at work. Findings include: During a visit to the kitchen on 8/10/17 at 10:45 AM, water was observed on the floors located in the warewashing and tray line areas. Warewashing was in progress and the steam table was getting set up for lunch service. In an interview on 8/10/17 at 10:50 AM, E11 (Food Service Director) stated that the drain pipe from the steam wells loses alignment with the floor drain whenever the steam table shifts, and water spills onto the floor. E11 also indicated there were no rubber mats in the kitchen for the wet areas. These findings were reviewed with E1 (NHA) and E3 (ADON) on 8/17/17 at 7:00 PM.	F 465	A. Drain pipe from steam table was aligned with the floor drain and wet area noted was dried no longer needing rubber mats. In order to protect residents in similar situations, the facility will continue to check the drain pipe from steam table is aligned with the floor drain and floor is not wet. B. Dietary Director/ Designee will conduct audit of the Steam table drain pipe to ensure water is draining into the floor drain and floor is dry to maintain a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Any findings will be addressed as residents residing in facility have ability to be impacted. C. The steam table drain pipe was not identified to be misaligned from the floor drain during the annual survey. Detailed below is the system change and monitoring the facility will do in order to ensure the problem does not recur and solutions are sustained. It is the practice of this facility to maintain a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Dietary Director/ designee will randomly check Drain pipe from the steam table to	

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F 465	Continued From page 68	F 465	ensure it is draining into the floor drain and not leaking onto the floor. The Staff Development Coordinator/ Designee will in-service dietary staff to ensure drain pipe from steam table is aligned and draining into the floor drain. D. Directory Director/ designee will perform audit of steam table drain pipe 5x for one week, then weekly for 3 weeks, and if appropriate, monthly for 2 months to ensure substantial compliance. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 514		10/1/17

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F 514	Continued From page 69 (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R43) out of 33 Stage 2 sampled residents, the facility failed to maintain medical records in accordance with accepted professional standards and practices that are accurately documented. Findings include: Cross refer to F315 example 2. Review of R43's clinical record revealed the following: On 7/2/17 at 7:12 AM, a nurse's note stated that R43 does not have a foley. From 7/2/17 through 7/26/17, the facility's licensed nursing staff were inaccurately signing off on the July 2017 eTAR that R43's foley was being maintained on 53 out of a total of 75 shifts.	F 514	A. The facility failed to maintain medical records in accordance with accepted professional standards and practices that are accurately documented. R43 was impacted by this deficient practice. R43's maintain indwelling catheter order was d/c'd on 9/6, there has been no documentation related to indwelling catheter since 9/6. R43 now has a 3 day bladder diary, urinary incontinence CARE AREA ASSESSMENT, identified voiding pattern, and an individualized toileting plan. In order to protect other residents in similar situations the facility will notify the resident's physician when there is a significant change in the resident's physical status which may require physician intervention such as discontinuing an order when it is no longer	

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F 514	Continued From page 70 22 shifts indicated that R43 did not have a foley. Review of R43's clinical record revealed a lack of evidence that her foley was replaced from 7/2/16 through 8/16/17. From 7/27/17 through 8/16/17, R43's foley use was placed on hold on R43's eTAR. Despite R43's foley use being on hold, the following progress notes inaccurately stated the following: - 7/29/17 at 11:51 AM, R43's foley was patent; - 8/10/17 at 2:39 PM, R43's foley was draining well; and - 8/12/17 at 3:08 PM, R43's foley was patent with no discomfort. During an interview on 8/17/17 at 9:26 AM, E3 (ADON) and E4 (Staff Development RN) reviewed R43's clinical record and confirmed the findings. The facility failed to maintain R43's medical record in accordance with accepted standards and practices that were accurately documented. Findings were reviewed with E1 (NHA), E3 and E4 during the Exit Conference on 8/17/17 at 7 PM.	F 514	appropriate reducing the potential for inaccurate documentation. B. Residents / patients with significant changes in their physical status, such as discontinued indwelling catheters residing in the facility have the ability to be affected by this deficient practice. DIRECTOR OF NURSING/ designee conducted an initial audit of discontinued indwelling catheters since 8/17/17 to ensure that the order was discontinued and documentation is appropriate. C. STAFF DEVELOPMENT COORDINATOR/ designee will in service licensed staff that when there is a significant change to a patient's physical status such as discontinued indwelling catheter that there is a need to alter treatment significantly, discontinue and existing treatment, or commence a new one, the physician will be notified, the treatment will be discontinued, and documented as appropriate. D. DIRECTOR OF NURSING/ designee will audit charts via the 24 hour report for significant changes to a patient's physical status such as discontinued indwelling catheter and there is a need to alter treatment significantly, discontinue and existing treatment, or commence a new one, and that the physician was notified, treatment was discontinued, and documented as appropriate. Audit will be conducted daily x2 weeks, weekly x2 weeks, monthly x2 months to ensure substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES - WILMINGTON	700 FOULK ROAD WILMINGTON, DE 19803

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F 514	Continued From page 71	F 514	Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Long Term Care
Residents Protection

3 Mill Road, Suite 306
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Manor Care Wilmington

DATE SURVEY COMPLETED: August 17, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from August 10, 2017 through August 17, 2017. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 117. The Stage 2 survey sample size was 33.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed on August 17, 2017: F157, F247, F248, F253, F272, F280, F314, F315, F353, F371, F372, F412, F465 and F514.		

Provider's Signature [signature] Title NHA Date 10/5/17